VENTURA COUNTY
HEALTH CARE PLAN

CARE VALUE POLICY

POLICY: Cushing's – Mifepristone Care Value Policy
- Korlym® (mifepristone tablets – Corcept, generic)

REVIEW DATE: 4/24/2024; effective 07/15/2024

OVERVIEW

Mifepristone, a cortisol receptor blocker, is indicated to control hyperglycemia secondary to hypercortisolism in adults with **endogenous Cushing's syndrome** who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery.[1]

Mifepristone should not be used for the treatment of type 2 diabetes mellitus unrelated to endogenous Cushing's syndrome.[1]

POLICY STATEMENT

This Care Value program has been developed to encourage the use of the Preferred Product. For the Non-Preferred Product only, the patient is required to meet the respective standard *Cushing's – Mifepristone Prior Authorization Policy* criteria. Requests for the Preferred Product does not have to meet standard Prior Authorization Policy criteria. Requests for Non-Preferred Product will also be reviewed using the exception criteria (below). All approvals are provided for 1 year in duration.

Documentation: Documentation will be required where noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and/or other information.

Automation: None.

Preferred Product: Generic mifepristone tablets
Non-Preferred Product: Korlym

RECOMMENDED EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Korlym	**1.** Patient meets BOTH of the following (A and B): **A)** Patient meets the standard *Cushing's – Mifepristone Prior Authorization Policy* criteria; AND **B)** Patient meets BOTH of the following (i and ii): **i.** Patient has tried generic mifepristone tablets; AND **ii.** Patient cannot continue to use generic mifepristone tablets due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.

REFERENCES

1. Korlym® tablets [prescribing information]. Menlo Park, CA: Corcept; March 2020.

History

Type of Revision	Summary of Changes	Review Date
New Policy	Effective 07/15/2024.	04/24/2024